## NEBRASKA PUBLIC HEALTH LABORATORY

UNIVERSITY OF NEBRASKA MEDICAL CENTER

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## SPECIAL INFLUENZA MICROBIOLOGY REQUISITION

PATIENT LAST NAME	FIRST NAME MI
<u>                                     </u>	DATE OF BIRTH AGE SEX
Submitting Laboratory Information Laboratory Name and Address	/ / M / F ADDRESS APT
Telephone: Fax Number:	COUNTY CODE STATE CODE SURVEILLANCE ID NUMBER
Contact Name (printed):	
Test approved by: Safranek/Williams/Other  Test approved by LPHD Name:	COLLECTION DATE COLLECTION TIME
Clinical Diagnosis:	
	yngeal Washing BALOther:
Avian Influenza Surveillance Testing - INFLU Submitting Facility: Hospital Senting	JENZA PCR Panel (CDC) nel Provider Other
Onset Date of Symptoms://201 Has th	nis pt received an antiviral? YES NO
Is this patient hospitalized?YES Is this patient pregnant?YES Is this patient a healthcare worker?YES Has this patient had close contact with animals (such as	
-	ses of H7N9 have recently been detected (at least 10 days prior
Rapid influenza diagnostic test performed:  Influenza A test results:PositiveNegative	Not Performed
Name of rapid influenza diagnostic test kit:	